OAH Docket No. 7-0900-17438-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of St. Louis Park Plaza Healthcare Center:
Survey Exit Date July 2, 2006.

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Richard C. Luis on September 26, 2006, at 9:30 a.m. at the Office of Administrative Hearings. The OAH record closed at the conclusion of the meeting on September 26, 2006.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DFPC), Minnesota Department of Health, 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill, Planner Principal of the Division of Compliance Monitoring, also attended the meeting.

The following persons made comments on behalf of St. Louis Park Plaza Healthcare Center, which is located at 3201 Virginia Avenue South, St. Louis Park, MN 55426: Tony Johnson, Executive Director; Sharon Oswalt, Social Work Director and Assistant Executive Director; Dawn Wozniak, Assistant Director of Nursing; John Freitas, Director of Nursing Services; and Allison Murkowski, Administrator in Training.

FINDINGS OF FACT

1. St. Louis Park Plaza Healthcare Center (Facility) is located in St. Louis Park, Minnesota. It is a 220 bed facility that provides a variety of nursing home services.[1]

TAG F 309

2. F 309 is a quality of care tag. Residents must receive the services and treatment necessary to achieve their highest practicable level of functioning, in accordance with a comprehensive assessment and a plan of care.[2] The facility must ensure that a resident attains optimal improvement or does not

[1] Statement of Tony Johnson
[2] Statement of Marci Martinson.

deteriorate, within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.[3]

3. Resident #1 is a 64 year old female resident.[4] Her diagnoses include Type II diabetes, bipolar disorder, moderate dementia, and maladaptive personality traits.[5] The resident has had several psychological assessments.[6] The resident's care plan indicates that the resident has dementia with impaired decision making skills, with periods of disordered thinking, periods of awareness and periods of lethargy.[7] The resident is not on any diabetic medications. The diagnosis of diabetes increases the resident's risk of ulcers on her feet and her psychological diagnoses indicate that the resident might not use good judgment in her compliance with treatments.[8]

4. Resident #1 developed a sore on her left great toe that was initially observed on December 5, 2005.[9] A podiatrist treated the ulceration on the left great toe on December 26, 2005. He noted a "Grade I DM (diabetic) foot ulcer, DM with peripheral neuropathy.[10] The podiatrist returned on January 26, 2005 and found that the wound was almost healed.[11] He indicated that the further wound care needed to include foot soaks and a gauze dressing.

5. Resident #1 began complaining about pain in her toe in February 2006. On February 22, 2006, a podiatrist again saw the resident and found a pressure ulcer on the great toe that showed signs of infection.[12] The podiatrist directed that the resident's foot be soaked daily for 15 to 20 minutes.[13]

6. The Facility's records indicate that the resident did not receive treatment.[14]

7. The podiatrist again visited the resident on March 30, 2006, at which time he found a foreign body in the wound that was removed.[15] The podiatrist ordered daily foot soaks with gauze or Band-Aid dressing.[16]

8. Nursing notes from March 31, 2006 show that the resident reported some concern regarding getting her foot soaked on a daily basis. The

[3] Statement of Marci Martinson.
[4] Facility Ex. M.
[5] Ex. G-1a; Statement of M. Martinson. There are two residents listed in tag F 309. The Facility is only disputing the facts that related to resident #1.
[6] Ex. G-58 & 59.
[7] Ex. G-6, 61
[8] Statement of Marci Martinson.
[9] Statement of M. Martinson.
[10] Ex. G-45.
[11] Ex. B. 46, 49.
[12] Ex. G-51-54.
[13] Ex. G-51.
[14] Statement of M. Martinson.
[15] Ex. G-54.
[16] Ex. G-54.

staff noted that the resident was not complying with treatment and preferred to go to the smoking room instead.[17]

9. The Facility did not develop another written plan of treatment.[18] Although it does not appear documented, the Facility offered to provide foot soaks at any time of the day to the resident.[19]

10. Nursing notes from April 9, 2006 indicate that the resident choose to wear slippers instead of shoes and that she was not coming to staff for foot soaks.[20]

11. On May 11, 2006, the podiatrist again saw the resident. The facility staff told the podiatrist that the resident was not seeking foot soaks. The podiatrist's progress note showed, "The ulcer is healing slowly, but there was sand within the ulcer base and no dressing? Wound care. Please be more diligent with the wound care. Soak left foot once daily in lukewarm H2O (water) for 20-30 minutes and dress with gauze or Band-Aid, RTC 2 wks."[21]

12. On June 16, 2006, nursing notes indicate that the resident's right foot hurt. [22] The foot had a raised area filled with pus and the surrounding skin was red and warm to the touch. The after-hours physician was called. He ordered an antibiotic until the resident saw her podiatrist.[23] The resident had a prior scheduled appointment with her podiatrist for Thursday, June 22, 2006.[24] There was no attempt to obtain an earlier appointment for the resident.

13. On June 22, 2006, the podiatrist again visited the resident. The podiatrist drained the abscess on the left foot and found a small amount of exposed bone.[25] The podiatrist also reported that there was a superficial ulcer on the outer aspect of the foot without significant signs of infection. The podiatrist prescribed a different medication and prescribed soaking both feet in lukewarm water and to dress it with dry gauze dressing.[26]

14. On the same date, the resident complained to the nursing staff about the care of her feet.[27] Nursing notes after June 22, 2006 only indicate that the resident was on an antibiotic and not that her feet were being soaked or that she was refusing foot care.

15. During the course of a survey on June 28, 2006, a registered nurse surveyor accompanied a facility LPN to inspect resident #1's feet. The resident was wearing slippers instead of shoes. The surveyor observed that there was no

[17] Ex. G-21a. Statement of D. Wozniak.
[18] Statement of M. Martinson.
[19] Statement of D. Wozniak.
[20] Ex. 21-b; Statement of Dawn Wozniak.
[21] Ex. G-55.
[22] Statement of D. Wozniak.
[23] Ex. G-23a, 42.
[24] Statement of D. Wozniak.
[25] Ex. G-56. This is a Stage IV ulcer. Statement of M. Martinson.
[26] Ex. G-56.
[27] Ex. G-23a.

drainage from the left great toe but that it remained painful to the touch. The right foot was found to have swollen yellow tissue with white slough and green drainage. The LPN observed the area was "hard." The surveyor observed a stage IV ulcer on the right foot with exposed bone.[28] The LPN was unable to state whether the areas observed were better or worse or how often the areas had been treated. There is no evidence that the facility revised the resident's care plan to increase compliance with the podiatrist's directions on care.[29]

16. The surveyor spoke to the podiatrist who indicated that there was a strong possibility of a bone infection and that the left foot appeared not to have been bathed in days.[30] The podiatrist described the ulcers as some of the worse he had seen.

17. The DFPC issued a deficiency at the scope and severity level J, immediate jeopardy, isolated.[31] The determination of immediate jeopardy is not made by the surveyor but instead is made by DFPC management staff.[32]

18. The Facility's medical director examined both of the resident's feet on June 29, 2006. He did not observe exposed bone nor did he find Stage IV pressure ulcers.[33] The resident's report of pain is inconsistent with a Stage IV wound. A Stage IV ulcer would be expected to have little pain since the nerves would have been damaged.[34]

19. When the resident returned to the podiatrist on June 30, 2006, the podiatrist described the wound on the left foot as superficial.[35]

20. The Facility notes that there is some confusion in the record about the location of the wound with exposed bone. [36] The Facility contends that the record shows that it failed to document the care it was providing the resident, not the absence of care itself.[37] The Facility also notes that the record shows a pattern of wound and healing, which it contends shows periods of compliance and periods of the resident's non-compliance with the treatment plan.[38]

21. The Facility believes that the "immediate jeopardy" designation is unwarranted because the resident showed no signs of illness.[39] The Facility believes that the appropriate designation would be harm that is not immediate jeopardy.[40] The Facility concedes that there was a deficiency.

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[28] Statement of M. Martinson.
[29] Statement of M. Martinson.
[30] Ex. H-4a.
[31] Ex. C.
[32] Statement of M. Martinson.
[33] Facility Ex. M.
[34] Statement of D. Wozniak.
[35] Statement of D. Wozniak.
[36] Statement of D. Wozniak.
[37] Statement of Tony Johnson; Statement of D. Wozniak.
[38] Statement of D. Wozniak.
[39] Facility Ex. E.
[40] Facility Ex. M.

TAG F 329

22. A facility must ensure that a resident's drug regimen must be free from unnecessary drugs.[41] The record indicates Resident #11 presented with a difficult medical situation and was prescribed many medications.[42]

23. Resident #11, a 71 year old female, had diagnoses that included psychiatric diagnoses of borderline personality disorder and major depression.[43] The resident received multiple psychotropic medications.[44] The resident had a history of falls. Some of the medications can increase the chance of falling. The resident was taking anti-anxiety medications including Clonazepam 0.5 mg and Buspar 10 mg, both administered three times a day, and antidepressant medications including Cymbalta, 60 mg twice a day, Trazodone, 150 mg at bedtime, and Effexor, 225 mg at bedtime. The resident also took antipsychotic medication, Seroquel 25 mg and sedative/hypnotic medication, Ambien 10 mg at bedtime.[45] Resident #11 has a very long medical history.

24. The facility's consultant pharmacist reviewed the resident's medications on January 31, 2006 and stated: "Resident is receiving Clonazepam 0.5 mg … Long acting benzodiazepines are not recommended in the elderly due to their long half-life leading to sedative side effects such as confusion, cognitive impairment, increased fall risk and unsteadiness." The pharmacist went on to state: "Please not a duplication in therapy with Cymbalta 60 mg daily , Effexor 225 mg daily, and Trazodone 150 mg daily. OBRA (federal) regulations suggest against use of multiple antidepressants. Please address need and benefit of using multiple drugs in a progress note."[46]

25. The use of multiple medications raises concerns in part because many of the medications have the same potential adverse reactions.[47]

26. The Facility's only responsive comment was from a nurse practitioner that indicated: "no change at this time resident in hospice end states."[48]

27. On February 6, 2006, the resident was seen by her attending physician who reported that the resident was receiving multiple psychiatric medications and that "this is being monitored."[49] The physician did not indicate how the medications were being monitored.

28. On March 22, 2006, the Facility's MED (Minimum Effective Dose) Committee reviewed the resident's medications and recommended that two of the psychotropic medications be discontinued. The report indicated that the

[41] 42 C.F.R. § 483.25(i)(1); Exs. 11 & 12.
[42] Statement of Sharon Oswalt.
[43] Ex. O-1a & O-6; Statement of M. Martinson; Statement of Sharon Oswalt; Facility Ex. S.
[44] Ex. 0-16-18; Statement of Sharon Oswalt.
[45] Ex. 0-16-18.
[46] Ex. 0-31, 33 and 36. .
[47] Statement of M. Martinson.
[48] Ex. 0-31.
[49] Ex. P-13.

resident's physician would be contacted.[50] There is no evidence in the record that the resident's physician was contacted.[51]

29. The resident was evaluated by a psychiatrist on May 9, 2006, who stated that he doubted that the patient was profiting form all her current psychotropic medications.[52] The psychiatrist recommended discontinuation of Buspar.

30. On May 23, 2006 the nurse practitioner restarted the resident on Buspar.[53] On May 31, 2006 the nurse practitioner ordered Ambien 10 mg at bedtime for the resident. The record does not have any evidence of monitoring sleep patterns prior to administering Ambien.[54] The record does not show that the Facility attempted to rule out other reasons for the resident's insomnia including the side effects of multiple drugs. The resident had been on hospice care but improved and by June 16, 2006 no longer qualified for hospice care.

31. On June 28, 2006, the surveyor conducted a telephone interview with the nurse practitioner regarding the resident's medications. The nurse practitioner stated that revisions to the resident's psychotropic medications had not been made because the resident had a long history of receiving psychotropic medications and she did not want to alter medication or dosages without input from a psychiatrist.

32. The DFPC issued a deficiency at the scope and severity level D, potential for more than minimal harm, isolated.[55]

33. The Facility attempted to have the resident see doctors but appointments were missed or the resident did not want to see the available doctor.[56] Facility staff was monitoring the resident and her complex medications. The Facility was relying upon the expert opinion of the evaluating psychiatrist, who did not feel he could take over treatment of the resident without permission.[57]

TAG F 174

34. Federal regulations provide that residents have the right to have reasonable access to the use of a telephone where calls can be made without being overheard.[58] The Department considers reasonable access to telephones without being overheard to include providing either cordless telephones or having telephone jacks in the residents' rooms.

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[50] Ex. P-3.
[51] Statement of M. Martinson.
[52] Ex. O-39.
[53] Statement of M. Martinson.
[54] Ex.0-18, 2-b; Statement of S. Oswalt.
[55] Ex. C.; Statement of M. Martinson.
[56] Statement of S. Oswalt.
[57] Statement of S. Oswalt.
[58] 483.10(k).

35. The surveyor conducted a group interview of residents and asked them to identify any concerns.[59] Group interviews of the residents in 1 North and the Evergreen units were conducted on June 27, 2006.[60] The residents indicated that the portable telephones did not work in their rooms or would not hold a charge.[61]

36. The surveyor conveyed these concerns to the Facility. The Facility responded that there had been no privacy complaints at the January 2006 residents' council meeting and that the Facility had worked on the telephones in the past.[62]

37. The Facility replaced the cordless telephones on July 3, 2006, after being informed.[63] Records from the Facility indicate on-going problems with telephones, in particular related to batteries.[64]

38. The deficiency for Tag 174 was issued at the scope and severity level B, a pattern of deficiencies that has potential for no more than minimal harm.[65]

39. These Findings are based on all of the evidence in the record. Citations to portions of the record are not intended to be exclusive references.

40. The Memorandum that follows explains the reasons for these Findings, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Findings.

41. The Administrative Law Judge adopts as Findings any Conclusions that are more appropriately described as Findings.

Based upon the exhibits submitted and the arguments made, and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That the deficiency with regard to the F 309 tag is supported by the facts in that there was evidence of a serious wound; however, the severity level should be reduced to a violation that was isolated and caused actual harm but was not immediate jeopardy (scope and severity level G).

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[59] Ex. T-1a.
[60] Ex. T-1a.
[61] Ex. T-1-8.
[62] Ex. T-13; Testimony of Tony Johnson.
[63] T-11.
[64] Facility Ex. B.
[65] Ex. C; Statement of M. Martinson.

2. The deficiency with regard to the F 329 tag is supported by the facts in that there is evidence that the concerns about multiple, possibly conflicting, medications were not addressed in a timely manner.

3. The deficiency with regard to the F 174 tag is not supported by the evidence.

Dated: October 24, 2006

/s/ Richard C. Luis
RICHARD C. LUIS
Administrative Law Judge

Reported: Taped, one tape
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d) (6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

In this request for Informal Dispute Resolution, Healthcare challenges survey findings under Minn. Stat. § 144A.10, subd.16 and submits three F-tags for determination.[66] The Department of Health conducted a survey of St. Louis Park Plaza Healthcare Center in June 2006 that was concluded on July 2, 2006. Based on the survey, the Department issued several statements of deficiency. In this IIDR, the Facility is disputing the deficiency related to Resident 1 and tag F-309, the deficiency related to Resident #11 and tag F-329 and tag F-174, which relates to telephone access.

F 309

[66] St. Louis Park Plaza Healthcare Center's request for IIDR, filed at OAH on August 7, 2006, disputed five F-tags, F174, F248, F280, F309, and F329. The Facility withdrew its dispute regarding F280 and MDH dropped F248. Therefore the three F-tags for consideration are F174, 309 and 329. Statement of Marci Martinson.

Federal law requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."[67] "Highest practicable" is defined as the highest level of functioning possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.[68]

The Department issued a deficiency tag for "quality of care" deficiencies. The regulation requires that the facility ensure that the resident obtain optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.[69] For the purpose of this tag, "highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status.

The Administrative Law Judge agrees that Resident #1 suffered actual harm and was at risk of further harm related to the inadequate assessment, monitoring, care planning and general care of the ulcers on her feet. The podiatrist notes document inadequate care of the ulcers on the feet of Resident #1. The resident had a pattern of developing ulcers which would heal and then reappear. The most recent episode began in February 2006. The podiatrist found foreign material in an ulcer on two occasions. This caused the podiatrist to question whether the wound was being kept clean. On June 22, 2006, the podiatrist drained an abscess and reported a small amount of exposed bone.

The Facility's testimony focuses on inconsistent testimony regarding the observation of exposed bone on June 28th. The surveyor reported finding exposed bone during an examination on June 28, 2006. The Facility's medical director did not find a Stage IV pressure ulcer on June 29, one day after the surveyor reported seeing a Stage IV ulcer. Representatives of the Facility testified that it had been offering and providing care to the resident that did not appear in the record. The record however shows that the podiatrist observed a small amount of exposed bone on June 22nd and that the podiatrist had questioned whether the resident was receiving appropriate treatment.

Resident #1, however, has psychological impairments that inhibit her judgment and inhibit care of her feet. Accordingly the severity of the sanction related to Resident #1 should be reduced to a violation that was isolated and caused actual harm but was not immediate jeopardy (scope and severity level G).

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[67] 42 C.F.R. § 483.25.
[68] Ex. E-1.
[69] 42 CFR § 483.25.

F 329

Resident # 11 received multiple antipsychotic medications. 42 C.F.R. § 483.25(l) requires that a resident's drug regimen must be free from unnecessary drugs. These regulations simply require that a resident's drug regimen be monitored, attempts be made to avoid duplicate drug therapy and reduce doses where feasible, and antipsychotic drugs not be used in excess of identified doses unless higher doses are necessary to maintain or improve the resident's functional status. These rules do not strictly prohibit the prescription of two or more antipsychotic drugs to a resident or require discharge of residents who are prescribed such drugs.

The consultant pharmacist expressed concerns about the resident's medications on January 31, 2006. The resident had a complicated drug regimen. While the Facility was relying upon expert advice regarding the drugs, the record shows that changes in drug therapy were discussed as early as January but that no effective response occurred until the surveyor's visit in June.

Tag F 329 has been substantiated.

F 174

Tag F 174 relates to resident complaints about cordless telephones. Telephones are exposed to a variety to conditions, only some of which a facility can control. Cordless telephones can have a multitude of problems. Their batteries can frequently cause problems. It is inappropriate here to sanction the Facility for problems with cordless telephone technology. The record does not support Tag 174.

R.C.L.